Meridian
Health Plan Inc.

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November 16, 2010

Julie Hamos
Director of Healthcare and Family Services
Illinois Dept. of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763-0002

Dear Ms. Hamos,

Enclosed you will find the recommendations from Meridian Health Plan related to the 2010 Governor's Healthcare Reform Implementation Council. There are several areas of Medicaid reform that could benefit from the expansion of the current managed care program. The following are the key areas where Meridian Health Plan is making recommendations:

1. Auto-Assignment of Members Based on Quality and Access
2. Member Enrollment Periods
3. Definitions of Network Providers

Our recommendations are laid out in an attachment identifying possible contract language and giving support for the suggestions. We feel that these changes will enhance our ability to provide high quality care for enrollees in the HFS Medical Programs, while ensuring effective utilization of limited State resources.

Thank you for your consideration of this request. If you have any questions, please feel free to contact me at (312) 705-2900 or through e-mail at mcotton@mhplan.com.

Sincerely,

Michael Cotton, FAHM
COO

Meridian Health Plan
2010 MCO Recommendations

1. Auto-Assignment of Members Based on Quality and Access

Recommendation:

Meridian Health Plan is recommending that HFS implement an auto-assignment methodology as a pilot program in all counties where a Medicaid health plan is offered in addition to Illinois Health Connect.

This proposed auto-assignment methodology would be utilized for enrollees that fail to voluntarily choose Illinois Health Connect or a Medicaid Health Plan at the time of enrollment. In that case, they would automatically be assigned to one of the two options based on a pre-determined formula. The auto assignment methodology could only be used in counties where a choice between Illinois Health Connect and a Medicaid Health Plan is available.

To implement the auto-assignment methodology, HFS would establish a formula that could include quality, compliance and access to care standards. These standards would be reviewed on a quarterly, bi-annual or annual basis for scoring. An example of a possible auto-assignment formula is included in Attachment A.

Rationale:

The auto-assignment methodology allows HFS to direct members toward the health care plans that meet its quality and efficiency goals.

Suggested Contract Language:

In Article IV, Enrollment, Coverage and Termination of Coverage, revise contract Section 4.1(e) as follows:

(e) Only a Head of Case may voluntarily enroll another Potential Enrollee. A Head of Case may enroll all other Potential Enrollees in his Case. An adult Potential Enrollee, who is not a Head of Case, may enroll him or herself only.

And add a new 4.1(m) that reads as follows:

(m) Participants that do not select a health care plan at the time eligibility is determined may be automatically assigned to a health plan or Illinois Health Connect through a methodology and criteria established by the Department. Only Participants residing within a county where both a health plan and Illinois Health Connect are approved shall be subject to automatic assignment. The Department shall be the sole authority for determining which Participants and counties will be subject to automatic assignment. Participants automatically assigned through the Department's auto-assignment methodology shall have the right to disenroll from the Contractor within 60 days of assignment.

All remaining sections would be re-numbered accordingly.

2. Member Enrollment Periods

Recommendation:

The current contract language allows an enrollee to change health plans continuously throughout the year. Meridian Health Plan feels that enrollees would be best served if they were locked into a health plan for a period of 12 months. We recognize that an enrollee should have the right to change their mind, so we suggest giving an enrollee 60 days from initial enrollment in the health plan to change plans without cause. If they have not decided to leave within that timeframe, then they would be locked into the plan for the full 12 months. This allows the health plan and the enrollee's physician to provide continuity of care.

Rationale:

Constant changing of health plans and providers hinders a managed care organization's ability to monitor the enrollee and make sure they are receiving necessary care. In addition, it negatively impacts continuous enrollment which limits the health plan's ability to calculate its HEDIS measures. Often times it takes several weeks or months to establish a relationship with an enrollee in order to educate them on the importance of preventive health and when to see their PCP versus going to the emergency room. Additionally, there is a reduction in administrative expenses for the State and ICEB if they don't have to constantly process changes every month.

Suggested Contract Language:

In Article IV, Enrollment, Coverage and Termination of Coverage, revise contract Section 4.4(a) Item 4 as follows:

(4) when an Enrollee elects to terminate coverage with the Contractor, he or she is required to contact the ICEB. Enrollees may make another health care choice within 60 days of initial enrollment and every 12 months thereafter. The Contractor shall comply with any Department policies then in effect to promote and allow interaction between the Contractor and the Enrollee seeking disenrollment prior to the disenrollment.

3. Definitions of Network Providers

Recommendation:

Meridian Health Plan is recommending that HFS allow for an expanded definition of a primary care provider. This would allow for additional mid-level practitioners to function as Primary Care Providers for health plan enrollees.

Rationale:

Frequently, Physician Assistants provide many of the covered services to the enrollee under the care of the supervising physician. The training that these practitioners receive is appropriate for treatment of acute minor illness or stable chronic conditions, which are common in primary care

settings. By allowing the health plan to implement mid-level practitioners as PCPs, it will increase access to care for the enrollees. This is especially true in rural counties.

Suggested Contract Language:

In Article I, Definitions, the following changes are suggested to the definitions listed below:

Primary Care Provider means a Physician, Physician Assistant, or Nurse Practitioner, specializing by certification or training in obstetrics, gynecology, general practice, pediatrics, internal medicine or family practice who agrees to be responsible for directing, tracking and monitoring the health care needs of, and authorizing and coordinating care for, Enrollees. The Contractor will permit Enrollees to choose a clinic as a PCP, provided that the provider forms submitted to the Department are completed consistent with the Department's requirements and the clinic has been approved by the Department to serve as a PCP. The Contractor will allow a specialist to perform as a PCP when the Enrollee's medical condition warrants management by a physician specialist. This may be necessary for those Enrollees with conditions such as diabetes, end-stage renal disease, HIV/AIDS, or other chronic disease or disability. The need for management by a physician specialist should be determined on a case-by-case basis in consultation with the Enrollee.

Women's Health Care Provider means a Physician, Physician Assistant, or Nurse Practitioner, specializing by certification or training in obstetrics, gynecology or family practice.

In Article V, Duties of Contractor, revise the language in Section 5.8(a) as follows:

(a) The Contractor shall assure that all Affiliated Providers are appropriately licensed by the State in which they are practicing medicine and are qualified to perform their services throughout the life of the Contract. If the provider participates in the HFS Medical Program, then this information must be documented for the Department. The Contractor must ensure that Affiliated Providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their State, even if they do not participate with the HFS Medical Program. Providers not participating in the HFS Medical Program must comply with NCQA credentialing requirements in order to be approved. The Contractor shall not enter into a contract with Providers that do not meet NCQA standards.

Attachment A
Proposed Auto-Assignment Methodology

General Criteria

Meridian's proposed auto-assignment methodology includes three key areas: Quality, Compliance and Access to Care. The following are the suggested weights for each of the three recommended areas:

- Quality – 50% of the Total Score
- Administrative Compliance – 25% the Total Score
- Access to Care – 25% of the Total Score

Depending upon the goals of HFS, the following are some of the performance metrics that may be included in each of the three areas:

Quality of Care

- Annual HEDIS Measures
- Encounter Data Measures

The performance expectations specified in the HFS Medicaid Health Plan contract could be utilized to create the Quality of Care portion of the Auto-Assignment Methodology.

Administrative Compliance

- Monthly Claims Processing Statistics
- Monthly Encounter Data Submission
- Complaints Per 1,000 Members

Access to Care

- Number of PCPs Open to New Members
- Percentage of Capacity previously approved by HFS

Scoring Methodology

The following is a recommended Scoring Methodology for the three key areas.

Quality of Care

HEDIS - The Medicaid Health Plan's HEDIS scores are compared to the latest NCQA percentiles. HFS would award 10 points for each HEDIS score above or equal to the 75th percentile, 5 points for each HEDIS score between the 50th percentile and the 75th percentile, and 0 points for HEDIS scores below the 50th percentile.

Encounter Data Measures - HFS would award points based on whether the plan achieves the performance monitoring standard of 50% for continuous enrollment. If the plan's 3-month average is above or equal to 50%, HFS would award 10 points; if the plan's 3 month average is

above or equal to 40% but less than 50%, FHS would award 5 points; if the plan's 3 month average is less than 40%, HFS would award 0 points.

Administrative

The following are some examples of the performance standards that could be used for administrative compliance:

- 90% of clean claims processed within 30 days
- $\leq$ 1% of claims in ending inventory more than 45 days old
- Report is received by due date and passes all HFS edits
- Encounter data is submitted by due date
- Data passes all edit and volume requirements established by HFS

For the administrative measures, HFS would award points based on the number of months that the plan achieves the performance monitoring standard for that measure. For example, if the plan meets the standard 3 of 3 months, HFS would award 15 points; if the plan meets the standard 2 of 3 months, HFS would award 7 points; if the plan does not meet the standard at least twice within the time frame, HFS would award 0 points.

Access to Care

This would be a two step process, calculated on county by county basis with the capacity and open PCPs ratio.

Step 1: Calculate plan's ratio of open PCP to approved capacity.

$$\text{Ratio of open PCPs to the approved capacity} = \frac{\text{Plan's approved capacity}}{\text{Plan's open PCPs}}$$

Step 2: Assign Points based on the capacity ratio of open PCP's to Capacity.

1 PCP to 500 Members or Less = 15 Points
Between 1 PCP to 500 Members and 1 PCP to 750 Members = 7 Points
1 PCP to Greater than 750 Members = 0 Points

Assignment of Membership

Under this example, a total of 90 points could be earned by each Medicaid Health Plan. Based on the points earned a tiered level of auto-assignment could be created as follows:

61-90 Points = 50% of Auto-Assignments
31-60 Points = 25% of Auto-Assignments
0-30 Points = 0% of Auto-Assignments

The remaining percentage of members that were not auto-assigned would be automatically enrolled in to Illinois Health Connect.